

Facility Name & ID Number Central Plaza Residential Home# 0017038 Report Period Beginning: 1/1/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	260	Intermediate (ICF)	260	95,160	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	260	TOTALS	260	95,160	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	87,854	104		87,958	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	87,854	104		87,958	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 92.43%

D. How many bed-hold days during this year were paid by Public Aid?

821 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)noneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 12/1/63

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Central Plaza Residential Home

0017038

Report Period Beginning:

1/1/04

Ending:

12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	268,262	40,041	13,755	322,058		322,058		322,058			1
2	Food Purchase		393,199		393,199	(27,398)	365,801	(1,331)	364,470			2
3	Housekeeping	321,041		54,569	375,610		375,610		375,610			3
4	Laundry		52,425		52,425		52,425		52,425			4
5	Heat and Other Utilities			196,963	196,963		196,963	1,772	198,735			5
6	Maintenance	251,621		172,944	424,565		424,565	2,810	427,375			6
7	Other (specify):*											7
8	TOTAL General Services	840,924	485,665	438,231	1,764,820	(27,398)	1,737,422	3,251	1,740,673			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,282,174	21,971	36,923	1,341,068		1,341,068		1,341,068			10
10a	Therapy											10a
11	Activities	95,497	15,054	5,346	115,897		115,897		115,897			11
12	Social Services	653,175		629,344	1,282,519		1,282,519	(600,000)	682,519			12
13	Nurse Aide Training											13
14	Program Transportation			1,504	1,504		1,504		1,504			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,030,846	37,025	673,117	2,740,988		2,740,988	(600,000)	2,140,988			16
	C. General Administration											
17	Administrative	363,903		866,238	1,230,141		1,230,141	(985,502)	244,639			17
18	Directors Fees			210,000	210,000		210,000	(150,000)	60,000			18
19	Professional Services			43,327	43,327		43,327	(11,376)	31,951			19
20	Dues, Fees, Subscriptions & Promotions			25,273	25,273		25,273	75	25,348			20
21	Clerical & General Office Expenses	440,857		58,247	499,104		499,104	(49,194)	449,910			21
22	Employee Benefits & Payroll Taxes			682,494	682,494	27,398	709,892		709,892			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,795	1,795		1,795		1,795			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			222,453	222,453		222,453	180	222,633			26
27	Other (specify):*			(868)	(868)		(868)	6,168	5,300			27
28	TOTAL General Administration	804,760		2,108,959	2,913,719	27,398	2,941,117	(1,189,649)	1,751,468			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,676,530	522,690	3,220,307	7,419,527		7,419,527	(1,786,398)	5,633,129			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number

Central Plaza Residential Home

#0017038

Report Period Beginning:

1/1/04

Ending:

12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			59,477	59,477		59,477	48,625	108,102			30
31	Amortization of Pre-Op. & Org.			39,491	39,491		39,491		39,491			31
32	Interest			146,490	146,490		146,490	(43,162)	103,328			32
33	Real Estate Taxes			138,395	138,395		138,395	(6,418)	131,977			33
34	Rent-Facility & Grounds			40,377	40,377		40,377	(20,994)	19,383			34
35	Rent-Equipment & Vehicles			15,563	15,563		15,563		15,563			35
36	Other (specify):*											36
37	TOTAL Ownership			439,793	439,793		439,793	(21,949)	417,844			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			142,740	142,740		142,740		142,740			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			142,740	142,740		142,740		142,740			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,676,530	522,690	3,802,840	8,002,060		8,002,060	(1,808,347)	6,193,713			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Central Plaza Residential Home

0017038

Report Period Beginning:

1/1/04

Ending:

12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	48,625	30		9
10	Interest and Other Investment Income	(42,945)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,331)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,025)	21		19
20	Contributions	(11,732)	19		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	90	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	868	27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,792,836)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,803,286)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(5,061)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (5,061)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,808,347)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Central Plaza Residential Home

ID# 0017038

Report Period Beginning: 1/1/04

Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Non-Allowable Fees	\$ (150,000)	18	1
2	Fees	(866,238)	17	2
3	Risk Management Fee	(500)	21	3
4	Penalties	2,234	21	4
5	Community Social Service	(600,000)	12	5
6	Resident Christmas Gifts	(1,250)	21	6
7	Non-Allowable Salaries	(119,264)	17	7
8	Non-Allowable Salaries	(45,743)	21	8
9	Prior Year Real Estate Taxes	(12,075)	33	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,792,836)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Central Plaza Residential Home

0017038

Report Period Beginning:

1/1/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,331)	0	0	0	0	0	0	0	0	0	0	(1,331)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,772	0	0	0	0	0	0	0	0	1,772	5
6	Maintenance	0	0	2,810	0	0	0	0	0	0	0	0	2,810	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,331)	0	4,582	0	0	0	0	0	0	0	0	3,251	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(600,000)	0	0	0	0	0	0	0	0	0	0	(600,000)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(600,000)	0	0	0	0	0	0	0	0	0	0	(600,000)	16
	C. General Administration													
17	Administrative	(985,502)	0	0	0	0	0	0	0	0	0	0	(985,502)	17
18	Directors Fees	(150,000)	0	0	0	0	0	0	0	0	0	0	(150,000)	18
19	Professional Services	(11,732)	0	0	356	0	0	0	0	0	0	0	(11,376)	19
20	Fees, Subscriptions & Promotions	0	0	0	75	0	0	0	0	0	0	0	75	20
21	Clerical & General Office Expenses	(49,194)	0	0	0	0	0	0	0	0	0	0	(49,194)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	180	0	0	0	0	0	0	0	0	180	26
27	Other (specify):*	868	0	5,300	0	0	0	0	0	0	0	0	6,168	27
28	TOTAL General Administration	(1,195,560)	0	5,480	431	0	0	0	0	0	0	0	(1,189,649)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,796,891)	0	10,062	431	0	0	0	0	0	0	0	(1,786,398)	29

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Central Plaza Residential Home# 0017038Report Period Beginning: 1/1/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 Utilities	\$	Barton Management Inc	100.00%	\$ 1,772	\$ 1,772	15
16	V	6 Repairs and Maint		Barton Management Inc		2,810	2,810	16
17	V	20 Dues, Fees, Subscriptions		Barton Management Inc				17
18	V	21 Clerical and General		Barton Management Inc				18
19	V	26 Insurance		Barton Management Inc		180	180	19
20	V	27 Emp. Ben. Gen. Admin		Barton Management Inc		5,300	5,300	20
21	V	33 Real Estate Taxes		Barton Management Inc		5,657	5,657	21
22	V	34 Rent Office Space		Barton Management Inc		19,006	19,006	22
23	V							23
24	V							24
25	V							25
26	V	34 Rent	40,000	Barton Management Inc			(40,000)	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 40,000			\$ 34,725	\$ * (5,275)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Central Plaza Residential Home# 0017038Report Period Beginning: 1/1/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	19 Professional Fees	\$	Barton Healthcare LLC	100.00%	\$ 356	\$ 356	15
16	V	20 Dues, Subscriptions		Barton Healthcare LLC		75	75	16
17	V	32 Interest		Barton Healthcare LLC		146,273	146,273	17
18	V							18
19	V	32 Interest	146,490				(146,490)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 146,490			\$ 146,704	\$ * 214	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Leon Shlofrock	Stockholder	Administrative	8.24	See Attached	See Attsched		Betcare II	\$ 0	17-3	1
2	Irwan Jann	Director	Director	13.93	N/A	1	N/A	Director Fee	30,000	18-3	2
3	Jeff Ross	Relative	Maintenance	0.00	N/A	40	100.00	Maint Salary	69,074	6-1	3
4	Marla Coquillet	Stockholder	Administrative	4.50	See Attached	See Attsched		Social Service	46,667	12-1	4
5	John Shlofrock	Stockholder	Administrative	8.80	See Attached	See Attsched		Admin Sal	23,333	17-1	5
6	Elisa Zusman	Stockholder	Office	8.80	See Attached	See Attsched		Office Sal	10,000	21-1	6
7	Jean Shlofrock	Stockholder	Office	0.00	See Attached	See Attsched		Office Sal	11,667	21-1	7
8	Paul Magit	Stockholder	Administrative	3.60	See Attached	See Attsched		Admin Sal	23,077	21-1	8
9	Paul Magit	Director	Director	3.60	N/A	1	N/A	Director Fee	30,000	18-3	9
10											10
11											11
12											12
13								TOTAL	\$ 243,818		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Barton Healthcare Inc
 Street Address 465 Central Ave
 City / State / Zip Code Northfield, IL
 Phone Number ()
 Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19 Professional Fees	Note Receivable	29	7	\$ 1,905	\$	6	\$ 356	1
2	20 Dues, Subscriptions	Note Receivable	29	7	400		6	75	2
3	32 Interest	Note Receivable	29	7	781,895		6	146,273	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 784,200	\$		\$ 146,704	25

Facility Name & ID Number Central Plaza Residential Home # 0017038 Report Period Beginning: 1/1/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Barton Mangement Inc
 Street Address 465 Central Ave
 City / State / Zip Code Northfield, IL 60093
 Phone Number ()
 Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 Utilities	Rental Income	214,800	8	\$ 9,514	\$	40,000	\$ 1,772	1
2	6 Repairs and Maint	Rental Income	214,800	8	15,089		40,000	2,810	2
3	20 Dues, Fes, Subscriptions	Rental Income	214,800	8			40,000		3
4	21 Clerical and General	Rental Income	214,800	8			40,000		4
5	26 Insurance	Rental Income	214,800	8	966		40,000	180	5
6	27 Emp. Ben. Gen. Admin	Rental Income	214,800	8	28,463		40,000	5,300	6
7	33 Real Estate Taxes	Rental Income	214,800	8	30,380		40,000	5,657	7
8	34 Rent Office Space	Rental Income	214,800	8	102,064		40,000	19,006	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 186,476	\$		\$ 34,725	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Barton Healthcare LLC	X		Working Capital		1/27/95	\$ 5,500,000	\$ 2,749,960	demand	variable	\$ 146,490	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 5,500,000	\$ 2,749,960			\$ 146,490	9	
	B. Non-Facility Related*												
10	Interest Income										(43,162)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (43,162)	14	
15	TOTALS (line 9+line14)						\$ 5,500,000	\$ 2,749,960			\$ 103,328	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

1. Real Estate Tax accrual used on 2003 report.		<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>		\$	170,896	1																				
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	145,942	2																				
3. Under or (over) accrual (line 2 minus line 1).				\$	(24,954)	3																				
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	156,931	4																				
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5																				
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.																										
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6																				
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	131,977	7																				
Real Estate Tax History:																										
Real Estate Tax Bill for Calendar Year:	1999	156,169	8	<table border="1"> <tr> <td></td> <td colspan="2">FOR OHF USE ONLY</td> <td></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2003</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td></td> <td>16</td> </tr> </table>				FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2003	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$		16
	FOR OHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2003	\$	13																							
14	PLUS APPEAL COST FROM LINE 5	\$	14																							
15	LESS REFUND FROM LINE 6	\$	15																							
16	AMOUNT TO USE FOR RATE CALCULATION \$		16																							
	2000	141,273	9																							
	2001	146,080	10																							
	2002	152,822	11																							
	2003	148,930	12																							

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Central Plaza Residential Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0017038

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE 847-441-8200 FAX #: 847-441-0800

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>16-09-300-011-0000</u>	<u>324 N Pine Ave</u>	\$ <u>365.00</u>	\$ <u>365.00</u>
2.	<u>16-09-300-004-0000</u>	<u>327 N Central Ave</u>	\$ <u>43,294.00</u>	\$ <u>43,294.00</u>
3.	<u>16-09-300-005-0000</u>	<u>321 N Central Ave</u>	\$ <u>93,443.00</u>	\$ <u>93,443.00</u>
4.	<u>16-08-405-020-0000</u>	<u>318 N Central Ave</u>	\$ <u>3,183.00</u>	\$ <u>3,183.00</u>
5.	<u>Barton Management Alloc</u>	<u>See Attached</u>	\$ <u>60,760.00</u>	\$ <u>5,657.00</u>
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>201,045.00</u>	\$ <u>145,942.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 90,310

B. General Construction Type:
 Exterior
 Brick
 Frame
 Number of Stories
 Wing#1-Wing#2-4

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☐ NO

If so, please complete the following:

1. Total Amount Incurred:
 Loan Amortization

2. Number of Years Over Which it is Being Amortized:
 See Attached

3. Current Period Amortization:

4. Dates Incurred:
 See Attached

Nature of Costs:
 See Attached

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Building	29,048	1974	\$ 57,000	1
2	Building-Parking Lot		2001	199,168	2
3	TOTALS	29,048		\$ 256,168	3

Facility Name & ID Number Central Plaza Residential Home

0017038

Report Period Beginning:

1/1/04

Ending:

12/31/04

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	260		1974	1964	\$ 385,508	\$	30	\$	\$	\$ 385,508	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Additions			1975	303,849		12.5			303,849	9
10	Building Additions			1976	53,526		12.5			53,526	10
11											11
12	Building Additions			1977	47,780		12.5			47,780	12
13	Building Additions			1978	66,037		2.5			66,037	13
14	Building Additions			1979	59,303		12.5			59,303	14
15	Building Additions			1980	24,816		12.5			24,816	15
16											16
17	Building Additions			1980	40,762		3			40,762	17
18	Building Additions			1981	34,255		3			34,255	18
19	Building Additions			1981	10,665		12.5			10,665	19
20	Building Additions			1982	13,492		10			13,492	20
21	Building Additions			1983	48,201		10			48,201	21
22	Building Additions			1984	52,327		10			52,327	22
23	Building Additions			1985	295,316		10			295,316	23
24	Building Additions			1986	144,407		10			144,407	24
25	Building Additions			1987	11,075		10			11,075	25
26	Building Additions			1988	10,240		10			10,240	26
27	Building Additions			1989	39,943		10			39,943	27
28	Building Additions			1990	65,848		10			65,848	28
29	Building Additions			1991	77,448		10			77,448	29
30	Building Additions			1992	89,051		10			89,051	30
31	Building Additions			1993	46,236		10			46,236	31
32	Building Additions			1994	220,966	7,120	10	22,097	14,977	220,966	32
33	Building Additions			1994	12,302	444	10	1,230	786	12,302	33
34	Building Additions			1994	1,430	52	10	143	91	1,430	34
35	Building Additions			1995	125,206	3,210	39	3,210		30,632	35
36	Curtains			1996	1,169	30	39	30		241	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Concrete Wall	1996	\$ 2,785	\$ 71	39	\$ 71	\$	\$ 571		37
38	Boiler Repair	1996	4,763	122	39	122	(0)	981		38
39	Windows	1996	10,000	256	39	256	(0)	2,059		39
40	Water Heater	1996	5,100	131	39	131	0	1,053		40
41	Water Line	1996	1,985	51	39	51	0	410		41
42	Sidewalk Repairs	1996	2,464	63	39	63	(0)	507		42
43	Storm Windows	1996	10,679	274	39	274	0	2,203		43
44	Electrical Circuit	1996	22,780	584	39	584	(0)	4,696		44
45	Elevator Selector	1996	2,632	67	39	67	(0)	539		45
46	House Pump	1996	22,527	578	39	578	0	4,649		46
47	Water Gate	1996	2,165	56	39	56	0	450		47
48	Air Conditioner Circuits	1997	6,845	176	39	176		1,312		48
49	Alarm Detectors	1997	634	16	39	16		124		49
50	Bath tub Refinish	1997	9,152	235	39	235		1,744		50
51	Bathroom Remodel	1997	5,135	132	39	132		1,006		51
52	Boiler Flame	1997	2,769	71	39	71		500		52
53	Ceiling Tiles	1997	623	16	39	16		122		53
54	Circuit Breakers	1997	1,920	49	39	49		362		54
55	Concrete	1997	1,300	33	39	33		249		55
56	Curtains	1997	749	19	39	19		145		56
57	Doorways	1997	6,660	171	39	171		1,233		57
58	Electrical	1997	1,361	35	39	35		246		58
59	Elevator	1997	42,595	1,092	39	1,092		8,570		59
60	Emergency Lights	1997	7,110	182	39	182		1,282		60
61	Fence	1997	4,500	115	39	115		848		61
62	Fire Alarm	1997	78,500	2,013	39	2,013		15,351		62
63	Flooring	1997	4,972	127	39	127		945		63
64	Kitchen Pipes	1997	2,200	56	39	56		404		64
65	Laundry Room	1997	24,750	635	39	635		4,907		65
66	Ramp Rail	1997	795	20	39	20		156		66
67	Remodeling	1997	141,653	3,632	39	3,632		26,472		67
68	Roof Repair	1997	14,458	371	39	371		2,891		68
69	Sensor Modules	1997	1,005	26	39	26		207		69
70	TOTAL (lines 4 thru 69)		\$ 2,728,724	\$ 22,331		\$ 38,185	\$ 15,854	\$ 2,272,850		70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,728,724	\$ 22,331		\$ 38,185	\$ 15,854	\$ 2,272,850	1
2	Water Valves	1997	1,060	27	39	27	(0)	206	2
3	Windows	1997	11,978	307	39	307	(0)	2,366	3
4	Bath Tub Refinish	1998	2,620	67	39	67	(0)	464	4
5	Blinds	1998	608	16	39	16	0	110	5
6	Electrical	1998	6,670	171	39	171	(0)	1,064	6
7	Elevator Remodel	1998	1,778	46	39	46	0	282	7
8	Emergency Lights	1998	10,323	265	39	265	0	1,822	8
9	Flooring	1998	1,600	41	39	41	(0)	265	9
10	Heat Pump	1998	1,213	31	39	31	(0)	192	10
11	Masonry/Electrical	1998	11,660	299	39	299	0	1,806	11
12	Paneling	1998	1,116	29	39	29	0	187	12
13	Remodeling	1998	5,053	130	39	130	0	895	13
14	Replace Pipes	1998	2,204	57	39	57	0	344	14
15	Roofing	1998	3,800	97	39	97	(0)	659	15
16	Spec. Consult	1998	232	6	39	6	0	36	16
17	Walk in Cooler	1998	11,565	297	39	297	0	1,943	17
18	Windows	1998	18,387	471	39	471	(0)	3,029	18
19	Wiring	1998	4,787	123	39	123	0	794	19
20	Activity Area	1999	10,937	280	39	280	(0)	1,599	20
21	Air Cleaners	1999	8,338	214	39	214	0	1,175	21
22	Café Line	1999	5,927	152	39	152	0	830	22
23	Doors	1999	4,225	108	39	108	(0)	618	23
24	Drain Line	1999	950	24	39	24	(0)	139	24
25	Electrical Panel	1999	985	25	39	25	(0)	134	25
26	Fire Dumper	1999	37,670	966	39	966	0	5,757	26
27	Flooring	1999	1,304	33	39	33	(0)	186	27
28	Heater Booster	1999	2,521	65	39	65	0	376	28
29	Masonry/Tuckpoint	1999	11,740	301	39	301	(0)	1,643	29
30	Renovate Elevator	1999	9,520	244	39	244	(0)	1,312	30
31	Roof Repair	1999	1,050	27	39	27	0	136	31
32	Spec. Consult	1999	2,474	63	39	63	(0)	378	32
33	Tubs & Valves	1999	5,422	139	39	139	(0)	718	33
34	TOTAL (lines 1 thru 33)		\$ 2,928,441	\$ 27,452		\$ 43,306	\$ 15,854	\$ 2,304,315	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,928,441	\$ 27,452		\$ 43,306	\$ 15,854	\$ 2,304,315	1
2	Windows	1999	30,303	777	39	777	0	4,239	2
3	Air Cleaners	2000	3,900	100	39	100	0	479	3
4	Bathroom Valve	2000	1,894	49	39	49	0	235	4
5	Carpeting	2000	749	19	39	19	(0)	77	5
6	CPU Unit	2000	5,580	143	39	143	(0)	685	6
7	Door Parts	2000	1,724	44	39	44	(0)	196	7
8	Electrical Panel	2000	2,305	59	39	59	(0)	267	8
9	Elevator Switch	2000	2,300	59	39	59	0	263	9
10	Fire Alarm Pump	2000	1,700	44	39	44	0	211	10
11	Fire Code Improvement	2000	8,131	208	39	208	(0)	997	11
12	Fire Damper	2000	5,620	144	39	144	(0)	630	12
13	Fire System	2000	66,705	1,710	39	1,710	(0)	8,053	13
14	Hand Rails	2000	6,602	169	39	169	(0)	745	14
15	Masonry	2000	11,840	304	39	304	0	1,497	15
16	Paint & Drywall	2000	12,400	318	39	318	0	1,498	16
17	Remodel Fire Pump Room	2000	3,100	79	39	79	(0)	339	17
18	Remodel Laundry Room	2000	3,500	90	39	90	0	386	18
19	Remodeling	2000	15,441	396	39	396	0	1,854	19
20	Remove Walls	2000	9,600	246	39	246	(0)	1,097	20
21	Shower Valves	2000	4,650	119	39	119	(0)	531	21
22	Sprinkler	2000	689	18	39	18	0	86	22
23	Steam Line	2000	2,734	70	39	70	(0)	341	23
24	Windows	2000	24,967	640	39	640	(0)	2,625	24
25	Heat Detectors	2001	880	23	39	23	0	85	25
26	Fire Alarm	2001	1,320	34	39	34	0	126	26
27	Pipe Add On Devices	2001	880	23	39	23	0	85	27
28	Pipe Add On Devices	2001	1,320	34	39	34	0	126	28
29	Fire Alarm	2001	1,997	51	39	51	(0)	189	29
30	Heat Detectors	2001	1,721	44	39	44	(0)	163	30
31	Heat Detectors	2001	990	25	39	25	(0)	93	31
32	Heat Detectors	2001	660	17	39	17	0	63	32
33	Water Heater	2001	4,950	127	39	127	0	471	33
34	TOTAL (lines 1 thru 33)		\$ 3,169,593	\$ 33,635		\$ 49,489	\$ 15,854	\$ 2,333,047	34

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,169,593	\$ 33,635		\$ 49,489	\$ 15,854	\$ 2,333,047	1
2	Wood Door	2001	570	15	39	15	0	55	2
3	Wood Door	2001	570	15	39	15	0	55	3
4	HVAC	2001	36,200	928	39	928	(0)	3,365	4
5	Heat Detectors	2001	2,660	68	39	68	(0)	247	5
6	Fire Alarm	2001	1,320	34	39	34	0	123	6
7	Panel	2001	440	11	39	11	(0)	40	7
8	Testing	2001	660	17	39	17	0	62	8
9	Plumbing	2001	4,050	104	39	104	0	377	9
10	Electrical	2001	1,180	30	39	30	(0)	109	10
11	Masonry	2001	2,450	63	39	63	0	223	11
12	Cubicle Curtains	2001	1,225	31	39	31	(0)	107	12
13	Reroof	2001	8,080	207	39	207	(0)	716	13
14	Elevator Repair	2001	17,412	446	39	446	(0)	1,543	14
15	Fencing	2001	4,000	103	39	103	0	348	15
16	Electrical	2001	2,485	64	39	64	0	216	16
17	Excavating/Paving	2001	28,083	720	39	720	(0)	2,310	17
18	Windows	2001	18,400	472	39	472	0	1,475	18
19	Windows	2001	2,900	74	39	74	(0)	231	19
20	Boiler Parts	2001	3,148	81	39	81	0	253	20
21	Iron Gate	2001	1,725	44	39	44	(0)	138	21
22	Front Walk	2001	2,950	76	39	76	0	237	22
23	Electrical	2001	7,528	193	39	193	(0)	587	23
24	Shower Room	2001	24,500	628	39	628	(0)	1,910	24
25	Water Heater	2001	4,950	127	39	127	0	386	25
26	Generator	2001	3,500	90	39	90	0	274	26
27	Plumbing	2001	1,340	34	39	34	(0)	103	27
28	Plumbing	2001	1,485	38	39	38	(0)	116	28
29	Plumbing	2001	1,635	42	39	42	0	128	29
30	Plumbing	2001	578	15	39	15	0	46	30
31	Smoke & Stove Add ons	2001	16,979	435	39	435	(0)	1,340	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,372,596	\$ 38,840		\$ 54,694	\$ 15,854	\$ 2,350,167	34

**Improvement type must be detailed in order for the cost report to be considered complete.

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 3,710,922	\$ 46,164		\$ 63,369	\$ 17,205	\$ 2,360,415	1
2	Bathroom #201	2004	6,500	104	39	167	63	104	2
3	Bathroom #405	2004	6,500	104	39	167	63	104	3
4	Bathroom #215	2004	6,500	104	39	167	63	104	4
5	Electromedia	2004	11,825	164	39	303	139	164	5
6	Electrical	2004	5,478	76	39	140	64	76	6
7	Drywall/Paint	2004	1,500	18	39	38	20	18	7
8	Scissor Gate	2004	3,600	42	39	92	50	42	8
9	Tubs	2004	3,640	43	39	93	50	43	9
10	Hall	2004	41,900	224	39	1,074	850	224	10
11	Bathroom	2004	46,460	149	39	1,191	1,042	149	11
12	Bathroom	2004	54,928	176	39	1,408	1,232	176	12
13	Roof/Fan	2004	5,800	19	39	149	130	19	13
14	Boiler	2004	79,311	255	39	2,034	1,779	255	14
15	Bathroom	2004	2,745	3	39	70	67	3	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,987,609	\$ 47,645		\$ 70,464	\$ 22,819	\$ 2,361,896	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 39,728	\$ 2,103	\$ 5,695	\$ 3,592	5-7	\$ 37,749	71
72	Current Year Purchases	12,266	2,054	2,054		5-7	2,054	72
73	Fully Depreciated Assets	1,009,037		14,467	14,467	5-7	1,009,037	73
74								74
75	TOTALS	\$ 1,061,031	\$ 4,157	\$ 22,216	\$ 18,059		\$ 1,048,840	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Chevy Blazer 1997	2000	\$ 21,295	\$ 1,775	\$ 4,259	\$ 2,484	5	\$ 12,465	76
77	Facility	Nissan Pathfinder 2001	2002	26,104	2,950	5,221	2,271	5	15,510	77
78	Facility	Ford Van 2003	2002	28,925	2,950	5,785	2,835	5	15,510	78
79										79
80	TOTALS			\$ 76,324	\$ 7,675	\$ 15,265	\$ 7,590		\$ 43,485	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,381,132	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 59,477	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 107,944	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 48,468	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,454,221	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Barton Management - Allocation				19,006			5
6								6
7	TOTAL				\$ 19,006			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: Schedule Attached \$15,563

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
	IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
	COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE _____
	HOURS PER AIDE _____	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language										
2	Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,257,301	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 100,000)	1,847,939		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	189,260		6
7	Other Prepaid Expenses	73,391		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest Receivable	1,771		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,369,662	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	256,168		13
14	Buildings, at Historical Cost	311,666		14
15	Leasehold Improvements, at Historical Cost	3,675,942		15
16	Equipment, at Historical Cost	1,137,352		16
17	Accumulated Depreciation (book methods)	(3,454,220)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Rush Barton Investment	330,075		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,256,983	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,626,645	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 210,055	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	82,402		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,306		31
32	Accrued Real Estate Taxes(Sch.IX-B)	156,931		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 460,694	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	2,749,960		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,749,960	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,210,654	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,415,991	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,626,645	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,333,117	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,333,117	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	682,874	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(600,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 82,874	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,415,991	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,641,822	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,641,822	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	42,945	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 42,945	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Phone Commissions</u>	167	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 167	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,684,934	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,764,820	31
32	Health Care	2,740,988	32
33	General Administration	2,913,719	33
	B. Capital Expense		
34	Ownership	439,793	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	142,740	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,002,060	40
41	Income before Income Taxes (line 30 minus line 40)**	682,874	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 682,874	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Central Plaza Residential Home# 0017038Report Period Beginning: 1/1/04Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,780	2,780	\$ 107,080	\$ 38.52	1
2	Assistant Director of Nursing	2,080	2,080	54,960	26.42	2
3	Registered Nurses	1,517	1,575	34,857	22.13	3
4	Licensed Practical Nurses	18,629	20,311	367,951	18.12	4
5	Nurse Aides & Orderlies	66,935	72,803	691,671	9.50	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,501	11,030	95,497	8.66	10
11	Social Service Workers	36,389	39,323	653,175	16.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,897	27,773	268,262	9.66	15
16	Dishwashers					16
17	Maintenance Workers	10,084	11,239	251,621	22.39	17
18	Housekeepers	35,210	38,383	321,041	8.36	18
19	Laundry					19
20	Administrator	2,080	2,080	82,615	39.72	20
21	Assistant Administrator	1,120	1,120	25,625	22.88	21
22	Other Administrative	5,200	5,200	255,663	49.17	22
23	Office Manager					23
24	Clerical	16,676	18,376	440,857	23.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,842	2,066	25,655	12.42	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	235,940	256,139	\$ 3,676,530 *	\$ 14.35	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	332	\$ 13,755	1-3	35
36	Medical Director	136	4,200	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	1,800	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	11	456	12-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	134	5,346	11-3	44
45	Social Service Consultant	257	11,568	12-3	45
46	Other(specify)				46
47	Psychological	252	11,320	12-3	47
48	Psychiatrist	120	6,000	12-3	48
49	TOTAL (lines 35 - 48)	1,337	\$ 54,445		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	814	\$ 30,923	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	814	\$ 30,923		53

Facility Name & ID Number Central Plaza Residential Home

0017038

Report Period Beginning: 1/1/04

Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Gwen Washington	Administrator	0	\$ 82,615
Keisha Jones	Admin Asst	0	25,625
Arnie Kanter	Administrative	0	48,360
John Shlofrock	Administrative	8.8	109,096
Rick Duros	CFO	0	58,456
Gary Weintraub	Legal	0	39,751
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 363,903
B. Administrative - Other			
Description			Amount
(Adjusted out on page 5)			\$ 866,238
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 866,238
C. Professional Services			
Vendor/Payee	Type		Amount
Lawrencewood Financial	Accounting		\$ 6,000
Pension Performance	Accounting		3,758
Bisys	Accounting		1,929
Alpha Data Services	Data Processing		4,566
Enloe Drugs	Computer Service		1,100
Barton Management Alloc	Computer Service		7,885
Personnal Planner	Unemployment Consult		1,815
Barton Management Alloc	Professional Fees		15,774
Barton Management Alloc	Legal		500
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 43,327
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 81,592
Unemployment Compensation Insurance			54,634
FICA Taxes			260,159
Employee Health Insurance			255,759
Employee Meals			27,398
Illinois Municipal Retirement Fund (IMRF)*			
Employee Head Tax			5,640
Employee Benefits - Other			11,705
Union Pension Contribution			13,005
TOTAL (agree to Schedule V, line 22, col.8)			\$ 709,892
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			7,262
Health Care Worker Background Check (Indicate # of checks performed 97)			679
Dues-IL Council LTC			13,783
Misc Dues & Subs & Licenses			2,424
City of Chicago License			1,100
Franchise Tax			100
Less: Public Relations Expense		(
Non-allowable advertising		(
Yellow page advertising		(
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 25,348
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			1,795
Entertainment Expense		(
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 1,795

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Decorating	12/00	\$ 4,257	3	\$ 1,419	\$ 1,419	\$	\$	\$	\$	\$	\$	\$
2	Decorating	12/01	3,819	3	1,273	1,273	1,273						
3	Decorating	12/02	2,652	3		884	884	884					
4	Decorating	12/03	1,225	3			408	408	409				
5	Decorating	12/04	292	3				97	97	98			
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 12,245		\$ 2,692	\$ 3,576	\$ 2,565	\$ 1,389	\$ 506	\$ 98	\$	\$	\$

Facility Name & ID Number Central Plaza Residential Home

STATE OF ILLINOIS

0017038

Report Period Beginning:

1/1/04

Ending:

Page 23

12/31/04

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Only CNA's
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on LTC \$13,783
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ n/a Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 142,740
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 27,398 Has any meal income been offset against related costs? n/a Indicate the amount. \$ n/a
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.